STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	06/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0000	This visit was for Investigation of Complaint IN00091793. Complaint IN00091793 - Substantiated. No deficiencies related to the allegations are cited. Unrelated deficiencies cited. Survey dates: June 22 and 23, 2011 Facility number: 000115 Provider number: 155208 AIM number: 100291080 Survey team: Jennie Bartelt, RN Census bed type: SNF/NF: 63 Residential: 9 Total: 72 Census payor type: Medicare: 4 Medicaid: 56 Other: 12 Total: 72 Sample: 11 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.	F0000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forthon the statement of deficiencies. This plan of correction is prepared and submitted because of requirements under state and federal law. Please accept this plan of correction as our credible allegation of compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F0157 SS=D	Quality review 6/29/11 by Suzanne Williams, RN A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on record review and interview, the facility failed to ensure the physician was notified of a change in resident condition for 1 of 4 residents reviewed related to physician notification in a sample of 11. (Resident E)	F0157	The facility will ensure this requirement is met through the following corrective measures:1. Resident E is deceased.2. All residents have the potential to be affected. Nurse's Notes reviewed for past 30 days to ensure physician	07/18/2011

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	Findings include: The clinical record for Resident E was reviewed on 6/22/11 at 8:25 a.m. The record indicated the resident's diagnoses included, but were not limited to, pneumonia and chronic airway obstruction. An Infection Control Report, dated 4/8/11 indicated the resident returned from the local hospital on that date with a prescription for an antibiotic for pneumonia. A physician's order, dated 5/19/11, indicated a chest x-ray was to be completed the following morning due to "wheeze and cough." The order also indicated the resident was to start on the antibiotic Zithromax for five days for upper respiratory infection. The Care Plan Worksheet for "Upper Respiratory Infection," dated 5/19/11, indicated, "Problem: The resident has an upper respiratory infection as evidenced by cough, [arrow pointing down] sats [oxygen saturation], abnormal lung sounds." An undated, handwritten note on the Care Plan indicated, "Resolved." A physician's order, dated 5/25/11		notification made when indicated.3. The Physician Notification with Acute Changes in Condition policy and procedure was reviewed and no changes were indicated at this time (see attachment A). Licensed staff were re-educated on this procedure. The DON or her designee will review Nurse's Notes and Respiratory Therapy notes daily on scheduled working days to ensure physicians are notified timely with changes in condition (see attachment B) indefinitely.4. Findings of these audits will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly.5. The above corrective measures will be completed on or before July 18, 2011.	

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	indicated the resident was placed on Prednisone (anti-inflammatory) and Doxycycline (antibiotic) for ten days due to upper respiratory infection. Physician's orders for June 2011 included, but were not limited to, the following respiratory treatments: Budesonide by nebulizer twice daily at 6:00 a.m. and 2:00 p.m.; Duoneb by nebulizer five times daily at 6:00 a.m., 10:00 a.m., 2:00 p.m., 6:00 p.m., and 10:00 p.m.; Duoneb by nebulizer every four hours as needed; oxygen at 2 liters per minute (LPM), as needed, to keep oxygen saturation greater than 90%. A Physician's Progress Note, dated 6/17/11 indicated, "Subjective: Asked to see re [about] pitting edema right foot....Has had ongoing cough. Objective: ...Chest - some rhonchi...Ext [extremity] - edema present...Plan: venous doppler lower extremities. Check Chem 7 [blood chemistry] /BNP [B-natriuretic PEP]. Elevate legs as tolerated. Consider increasing Lasix based on labs/clinical status. Await lab results. Overall prognosis is poor due to dementia/advanced chronic obstructive pulmonary disease...." Nurse's Notes indicated the following related to respiratory assessment:			

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6/17/11 at 10:45 a.m., "...O2 [oxygen] sat [saturation] 96% RA [room air]."

6/18/11 at 9:15 p.m., "...Sa O2 [oxygen saturation] - 94% L/S [lung sounds] dim [diminished]...."

6/19/11 at 4:20 a.m., "...O2 sat 92% L/S CTA [clear to auscultation]...."

6/19/11 at 11:00 a.m., "...O2 sat 96% RA"

6/19/11 at 9:05 p.m., "...Sa O2 - 96% L/S - clear & dim...."

6/20/11 at 8:00 p.m., "Tol [tolerated] neb [nebulizer] tx [treatment] [symbol for no] distress...LS [symbol for with] crackles...."

6/20/11 at 10:30 p.m., "Scattered crackles - exp. [expiratory] wheeze LLL [left lower lobe] - [symbol for no] productive cough. [arrow pointing up] SOA [shortness of air] upon minimal exertion...."

6/21/11 at 1:00 p.m., "...Placed on MD list for 6/22/11 for [arrow pointing down] O2 sats chest congestion edema B [bilateral] feet...."

Respiratory Therapy Notes for 6/14 through 6/21/11 indicated Resident E's

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	Duoneb treatment was administered three times daily on each of those dates. Documentation indicated the resident's oxygen saturation measured after each treatment was between 95 and 99%. A Respiratory Therapy Note for 6/21/11 at 1:54 p.m., indicated, "Res [resident's] lungs sounding more coarse wet with rhonchi throughout the day, Sats in mid to low 80's without O2. Day shift nurse didn't want to apply O2 d/t [due to] sat increased with neb [nebulizer] but at this time resp [respirations] very labored, Sat 82% on RA. O2 applied at 2 LPM, Sat 92% on 2 LPM and after neb." Nurse's Notes indicated: 6/21/11 at 9:15 p.m., "O2 sat 93% [symbol for with] O2 @ 2 LPM per N/C HOB [head of bed] [arrow pointing up], [symbol for without] O2, O2 sat 80% wheezes. rhonchi....on list to see [name of doctor]." 6/21/11 at 11:15 p.m., "Res awake moaning. Checked resident O2 @ 86% temp [temperature] 99.4. Adm [administered] prn [as needed] Tylenol per order & p/p [policy and procedure]." Documentation in the Nurse's Notes and Respiratory Therapy Notes failed to indicate the resident's physician was			

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	notified of the resident's condition. A Nurse's Note on 6/22/11 at 1:40 a.m. indicated the resident had expired. During interview on 6/23/11 at 2:10 p.m., the Director of Nursing provided a statement from Resident E's physician, who she indicated was the facility's medical director. The statement was dated 6/22/11 at 5:11 p.m., and indicated the physician had been requested to review Resident E's record and indicated, "...Her care had been discussed by myself with her POA [power of attorney] and with nursing....The care provided followed care discussed with POA. I concur with nursing decision not to call with change in O2 sat due to above factors. Indeed, I would have politely reminded the nurse of the diagnosis/poor prognosis/importance of keeping patient comfortable. No new orders would have been given unless patient showed evidence of being uncomfortable/needing additional medication for comfort needs." During interview on 6/23/11 at 4:15 p.m., LPN #24 indicated the physician's orders for Resident E did not include an order for comfort measures only. On 6/23/11 at 2:10 p.m., the Director of Nursing provided the facility's policy			

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	entitled, "Physician and Family Notification Procedure." Procedure #2, which was underlined, indicated, "Notify the physician of any change in condition that may or may not warrant a change in the treatment plan." 3.1-5(a)(2) 3.1-5(a)(3)			
F0164 SS=E	The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. Based on observation, interview, and	F0164	The facility will ensure this requirement is met through	07/13/2011

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	record review, the facility failed to ensure the resident's privacy was maintained during care for 6 of 6 residents reviewed for privacy during care in a sample of 11 residents. (Residents B, C, H, I, K, and J) The deficient practice also affected 1 of 11 sampled residents (Resident L) when her roommate's privacy was not maintained. Findings include: 1. On 6/22/11 at 5:15 a.m., CNA #11 was observed providing personal care for Resident B. The curtain between bed and door into the hallway/common area of the nursing unit was not pulled closed. CNA #11 provided incontinent care and assisted the resident to partially don her pants. During interview at this time, CNA #11 indicated she would get the nurse to help her pull the resident's pants up and assist her to transfer to the wheel chair. Without pulling the curtain, and leaving the room door open, CNA #11 exited the room. The resident remained lying uncovered in bed, with her pants down to the thighs, waiting for CNA #11 and the nurse to return. 2. On 6/22/11 at 5:30 a.m., CNA #17 and RN #8 were observed providing incontinent care for Resident C. Resident C's roommate, Resident L, was seated in		the following corrective measures:1. Residents B, C, H, I, K, J and L were not harmed.2. All residents have the potential to be affected. See below for corrective measures.3. The Pre/Post Basic Nursing Skills Policy and Procedure was reviewed and no changes were indicated at this time (see attachment C). Nursing staff were re-educated on this procedure. The concern was discussed with the physician involved as well. The DON or her designee will randomly observe staff prviding personal care three (3) times daily, on scheduled working days, for two (2) weeks, then three observations per week for four (4) weeks, then three observations per month for two months, then quarterly thereafter to ensure privacy is maintained. Further, she will observe one physician interaction with a resident per week for four weeks, then one per month for two months, then one per quarter to ensure privacy is maintained (see attachments D and E).4. The findings of these audits will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly.5. The above corrective measures will be completed on or bvefore July 13, 2011.	

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	her wheel chair between the two beds in the room. The curtain between the beds was not pulled, and the curtain between the bed and the door was not pulled. The resident's bed covers were removed, and care provided included cleansing of the urine and stool from the resident's perineal area, application of a barrier cream, and repositioning of the resident. The resident's lower body was uncovered as RN #8 opened the door and left the room to obtain needed supplies. 3. On 6/22/11 at 6:05 a.m., CNAs #3 and #7 were observed providing morning care for Resident I. The curtain between the bed and door to the hallway was not pulled. CNAs #3 and #7 provided incontinent care and applied the resident's brief. Before the resident's pants were applied, a knock was heard at the door. The resident was lying in bed, and the curtain between the bed and door remained open. CNA #5 opened the door, put her head into the room, and said, "Do you want report now?" 4. On 6/22/11 at 12:00 noon, MD #21 was observed at the nurse's station located within the dining/activity room on the secured unit. Residents were seated at tables in the dining room, and staff were serving lunch trays. MD #21 was observed to go the chair where Resident H			

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	was seated. MD #21 stated to Resident H, "Mr. [name], you're going to fall asleep right in your food." The doctor then asked staff, "Is this typical for [name of Resident H] - is this how he usually is?" The doctor put her stethoscope to the resident's chest and stated, "Mr. [Name of Resident H], I'm going to listen to your heart." MD #21 asked staff, "Do we usually put him back to bed when he's like this?" 5. On 6/22/11 at 1:05 p.m., LPN #12 was observed placing a blood pressure cuff around the upper left arm of Resident K. The resident was seated in the dining/activity area of the secured unit. Other residents were in the room, and the Activities Director for the unit was assisting them with activities. After Resident K's blood pressure was measured, LPN #12 used an ear thermometer to measure the resident's temperature on the left ear. 6. On 6/22/11 at 1:30 p.m., CNAs #15 and #9 were observed providing toileting assistance for Resident J. The resident was pushed into her room in her wheel chair, and a bedside commode was placed next to the resident's wheel chair. The curtain between the door and the wheel chair/bedside commode was not pulled. The resident was assisted to stand and			

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	pivot to the commode, as her pants were pulled down. After the resident urinated in the commode, her pants were pulled up as she was assisted to stand and pivot and take steps to her bed. After the resident was in bed, her pants were removed, and incontinence care was provided. During the care, a knock was heard at the door. The curtain between the bed and door remained open. CNA #15 indicated "just a minute," but the door opened, and Restorative Aide #18 looked directly into the room. The Director of Nursing provided facility policies including a copy of "Your Rights as a Nursing Home Resident" on 6/23/11 at 2:10 p.m. Review of the document indicated, "...You have the right to:...Privacy in your room and during bathing, medical treatment, and personal care." 3.1-3(p)(2) 3.1-3(p)(4)			
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to ensure respiratory medications were administered as ordered	F0282	The facility will ensure this requirement is met through the following corrective measures:1. Resident E is deceased.2. All	07/18/2011

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	for 1 of 2 residents reviewed related to respiratory medications in a sample of 11. (Resident E) Findings include: The clinical record for Resident E was reviewed on 6/22/11 at 8:25 a.m. The record indicated the resident's diagnoses included, but were not limited to, pneumonia and chronic airway obstruction. Physician's orders for June 2011 included, but were not limited to, the following respiratory treatments: Duoneb by nebulizer five times daily at 6:00 a.m., 10:00 a.m., 2:00 p.m., 6:00 p.m., and 10:00 p.m.. The Medication Administration Record (MAR) for June 2011 indicated the following related to the resident's respiratory treatments for June 1 through 21, 2011: Duoneb was administered five times daily, as ordered, on 6/1, 6/9, 6/11, 6/12, 6/15, and 6/20/11. The 10:00 p.m. dose of Duoneb was not administered on any of the other 15 dates. The 6:00 p.m. dose also was not administered on 6/8/11. During interview completed on 6/22/11 at		residents receiving respiratory therapy have the potential to be harmed. All residents respiratory therapy MAR's were audited to ensure treatments are being administered as ordered.3. Licensed nursing staff were re-educated on the Physician's Orders and Medication Administration policies (see attachments F and G). Additionally, all were inserviced and the need to review the respiratory MAR's when a respiratory therapist is not present in the facility, as nursing is then responsible to administer those treatments as ordered. The DON or her designee will monitor the respiratory MAR's to ensure treatments are administered as ordered daily on scheduled working days for two weeks, then twice weekly for two weeks, then weekly for two months, then monthly thereafter (see attachment H).4. The findings of these audits will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly.5. The above corrective measures will be completed on or before July 18,2011.	

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	3:15 p.m., the Director of Nursing indicated the respiratory therapists provide all respiratory treatments between 5:00 a.m. and 5:30 p.m. seven days a week. She indicated nurses provide the respiratory treatments at other times and the 10:00 p.m. doses were missed on the dates indicated. 3.1-35(g)(2)			
F0309 SS=D	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, record review, and interview, the facility failed to ensure care was planned and implemented to manage pain for 1 of 1 resident reviewed related to pain in a sample of 11 residents. (Resident C) Findings include: On 6/22/11 at 5:30 a.m., CNA #17 and RN #8 were observed providing incontinent care for Resident C. CNA #17 told the nurse they were going to change and reposition the resident. The resident was lying in bed on a specialty mattress with the heels on a z-flow pillow. The resident was positioned slightly toward the right, with a pillow behind the	F0309	The facility will ensure this requirement is met through the following corrective measures:1. A plan of care related to pain for resident C was implemented.2. All residents have the potential to be affected. All plans of care were reviewed to ensure plans of care for pain were present if indicated.3. The policies and procedures for Care Plan Development and Pain Management were reviewed and no changes were indicated at this time (see attachments I and J). Licensed nursing staff were re-educated on those policies and certified nursing staff were also re-educated on Pain Management. The DON or her designee will randomly observe staff providing personal care	07/18/2011

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	back. The resident's right arm was on a pillow. CNA #17 indicated the arm was elevated to help with pain. As the resident's perineal area was cleansed, she grimaced. CNA #17 indicated to the resident they would "try not to move you too much - I know it hurts." RN #8 indicated, "It hurts when she moves." As the resident was repositioned, she moaned, and RN #8 indicated, "I know you're in pain. I feel bad. I hate to do that." When the repositioning was completed, RN #8 indicated to Resident C, "You don't look like you're feeling too good. You want pain medicine?" The resident nodded, "Yes," and the nurse indicated she was going to get the pain medication and would return. The clinical record for Resident C was reviewed on 6/22/11 at 8:45 a.m. The record indicated the resident was admitted on 5/2/11 with diagnoses including, but not limited to, "pain, not otherwise specified/other chronic pain." A "Pain Assessment - Cognitively Impaired," dated 5/4/11, indicated the resident expressed pain by grimacing, tearing, moaning, crying, whimpering, rubbing body parts, and irritability. The quarterly (sic) Minimum Data Set (MDS) Assessment, dated 5/14/11,		three (3) times daily, on scheduled working days, for two (2) weeks, then three observations per week for four (4) weeks, then three observations per month for two months, then quarterly thereafter to ensure pain is addressed accordingly. Further, she will randomly review 5 resident's plans of care weekly to ensure pain is addressed if indicated for four weeks, then 5 per month for two months, then quarterlty (see attachments K and L).4. The findings of these audits will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly.5. The above corrective measures will be completed on or before July 18, 2011.	

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	indicated the resident had indicators of pain or possible pain daily. During interview on 6/22/11 at 9:20 a.m., the Director of Nursing indicated the MDS is now considered the facility's assessment for pain, and that the resident's care plan related to pain should be in her clinical record. Physician's orders for June 2011 included, but were not limited to, Duragesic (pain medication) patch, 50 mcg, change every three days; Lortab 10/500, take 1 every four hours as needed for pain; morphine sulfate (Roxanol), 100 mg/5 ml, take 0.5 ml every two hours as needed for moderate pain; and Roxanol, 1 ml, every two hours as needed for severe pain. The PRN (as needed) Medication Flow Sheet for June 1 through 22, 2011, indicated the resident had received pain medication 26 times. Each time pain medication was administered, the pain was rated at "5 worst pain possible" except 6/13/11 at 4:00 p.m. when the pain rating was "4 very severe pain." Attempted interventions prior to the pain medication administration was "Position change" on each entry. Medications administered included Roxanol, 1 ml and 0.5 ml and Lortab 10/500. The medication was indicated as "Effective"			

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	for each administration. During interview completed on 6/22/11 at 3:15 p.m., the Director of Nursing indicated Resident C's MDS should have triggered for a care plan related to her pain. During interview on 6/23/22 at 2:10 p.m., the Director of Nursing provided copy of an inservice presentation she indicated would be provided to nurses. The inservice indicated, "Please ensure that prior to any potentially pain causing experience (i.e. dressing change, T&R [turn and reposition], etc.) that a resident is premedicated [symbol for with] pain meds [medications] if requested, or if known to have increased pain during such procedures." 3.1-37(a)			
F0328 SS=D	The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. Based on interview and record review, the facility failed to ensure the resident was	F0328	The facility will ensure this requirement is met through the following corrective measures:1.	07/18/2011

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	assessed and care was planned and implemented for a resident with signs and symptoms of respiratory illness for 1 of 2 residents reviewed related to respiratory care in a sample of 11. (Resident E) Findings include: During interview on 6/22/11 at 4:55 a.m., CNA #11 indicated Resident E expired earlier during the night due to pneumonia. CNA #11 indicated the resident had been coughing, and her oxygen saturation levels were low, and she passed away. CNA #11 indicated the resident's passing was a shock. During interview on 6/22/11 at 5:05 a.m., LPN #2 indicated Resident E had CHF (congestive heart failure), had been on an antibiotic for pneumonia and had a low grade temperature. LPN #2 indicated the resident was [age] years old, and the "body wears out." The clinical record for Resident E was reviewed on 6/22/11 at 8:25 a.m. The record indicated the resident's diagnoses included, but were not limited to, pneumonia and chronic airway obstruction. A note written in bold handwriting in the front of the record indicated, "Do not send		Resident E is deceased. There was a care plan present for her chronic respiratory disease, which addressed assessment for signs and symptoms to monitor for which included increased edema, adventitious breath sounds and productive cough.2. All residents have the potential to be affected. See below for corrective measures.3. The policies on Nursing Charting and Care Plan Development and Review were reviewed and no changes were indicated at this time (see attachments L and I). Licensed staff were re-educated on these policies. The DON or her designee will review Nurse's Notes daily, on scheduled work days, to determine if changes in condition have occurred, been assessed appropriately, timely physician notification is made and the condition is care planned (see attachment B) indefinitely.4. The findings of these audits will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly.5. The above corrective measures will be completed on or before July 18, 2011.	

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	Res [resident] to hospital under any circumstances per [name] res guardian." The note was dated 9/12/10, and also indicated, "P.S. Keep comfortable here!" The Care Plan Worksheet for "Pneumonia," dated 4/8/11, indicated the "Problem: The resident has pneumonia and is at risk for decreased oxygen saturation." An undated, handwritten note on the Care Plan indicated, "Resolved." An Infection Control Report, dated 4/8/11 indicated the resident returned from the local hospital on that date with a prescription for an antibiotic for pneumonia. During interview on 6/23/11 at 4:25 p.m., the Director of Nursing indicated the facility would call the family of Resident E about sending her to the hospital, and the family would decide if the resident should go to the hospital or not. A physician's order, dated 5/19/11, indicated a chest x-ray was to be completed the following morning due to "wheeze and cough." The order also indicated the resident was to start on the antibiotic Zithromax for five days for upper respiratory infection. The Care Plan Worksheet for "Upper			

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	Respiratory Infection," dated 5/19/11, indicated, "Problem: The resident has an upper respiratory infection as evidenced by cough, [arrow pointing down] sats [oxygen saturation], abnormal lung sounds." An undated, handwritten note on the Care Plan indicated, "Resolved." A physician's order, dated 5/25/11 indicated the resident was placed on Prednisone (anti-inflammatory) and Doxycycline (antibiotic) for ten days due to upper respiratory infection. Physician's orders for June 2011 included, but were not limited to, the following respiratory treatments: Budesonide by nebulizer twice daily at 6:00 a.m. and 2:00 p.m.; Duoneb by nebulizer five times daily at 6:00 a.m., 10:00 a.m., 2:00 p.m., 6:00 p.m., and 10:00 p.m.; Duoneb by nebulizer every four hours as needed; oxygen at 2 liters per minute (LPM), as needed, to keep oxygen saturation greater than 90%. During interview on 6/22/11 at 10:30 a.m., the Director of Nursing indicated Resident E did not have a current care plan related to her respiratory condition, since she was not currently on an antibiotic. The Director of Nursing indicated a care plan is developed when the Infection Control Practitioner is			

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	informed a resident has an infection. A Physician's Progress Note, dated 6/17/11 indicated, "Subjective: Asked to see re [about] pitting edema right foot....Has had ongoing cough. Objective: ...Chest - some rhonchi...Ext [extremity] - edema present...Plan: venous doppler lower extremities. Check Chem 7 [blood chemistry] /BNP [B-natriuretic PEP]. Elevate legs as tolerated. Consider increasing Lasix based on labs/clinical status. Await lab results. Overall prognosis is poor due to dementia/advanced chronic obstructive pulmonary disease...." Nurse's Notes indicated the following related to respiratory assessment: 6/17/11 at 10:45 a.m., "...O2 [oxygen] sat [saturation] 96% RA [room air]." 6/18/11 at 9:15 p.m., "...Sa O2 [oxygen saturation] - 94% L/S [lung sounds] dim [diminished]...." 6/19/11 at 4:20 a.m., "...O2 sat 92% L/S CTA [clear to auscultation]...." 6/19/11 at 11:00 a.m., "...O2 sat 96% RA" 6/19/11 at 9:05 p.m., "...Sa O2 - 96% L/S - clear & dim...."			

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6/20/11 at 8:00 p.m., "Tol [tolerated] neb [nebulizer] tx [treatment] [symbol for no] distress...LS [symbol for with] crackles...."

6/20/11 at 10:30 p.m., "Scattered crackles - exp. [expiratory] wheeze LLL [left lower lobe] - [symbol for no] productive cough. [arrow pointing up] SOA [shortness of air] upon minimal exertion...."

6/21/11 at 1:00 p.m., "...Placed on MD list for 6/22/11 for [arrow pointing down] O2 sats chest congestion edema B [bilateral] feet...."

Respiratory Therapy Notes for 6/14 through 6/21/11 indicated Resident E's Duoneb treatment was administered three times daily on each of those dates. Documentation indicated the resident's oxygen saturation measured after each treatment was between 95 and 99%.

A Respiratory Therapy Note for 6/21/11 at 1:54 p.m., indicated, "Res [resident's] lungs sounding more coarse wet with rhonchi throughout the day, Sats in mid to low 80's without O2. Day shift nurse didn't want to apply O2 d/t [due to] sat increased with neb [nebulizer] but at this time resp [respirations] very labored, Sat 82% on RA. O2 applied at 2 LPM, Sat

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92% on 2 LPM and after neb."

6/21/11 at 9:15 p.m., "O2 sat 93% [symbol for with] O2 @ 2 LPM per N/C HOB [head of bed] [arrow pointing up], [symbol for without] O2, O2 sat 80% wheezes. rhonchi....on list to see [name of doctor]."

6/21/11 at 11:15 p.m., "Res awake moaning. Checked resident O2 @ 86% temp [temperature] 99.4. Adm [administered] prn [as needed] Tylenol per order & p/p [policy and procedure]."

Documentation in the Nurse's Notes failed to indicate the resident's physician was notified of the resident's condition as indicated in Nurse's and Respiratory Therapist's Notes.

A Nurse's Note on 6/22/11 at 1:40 a.m. indicated the resident had expired.

The Medication Administration Record (MAR) for June 2011 indicated the following related to the resident's respiratory treatments:

Budesonide was administered two times daily June 1 through June 21, 2011.

Duoneb was administered five times daily, as ordered, on 6/1, 6/9, 6/11, 6/12,

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	6/15, and 6/20/11. The 10:00 p.m. dose of Duoneb was not administered on any of the other dates. Duoneb was administered on an as needed (prn) basis on 6/21/11 at 11:50 [a.m. or p.m. not specified]. No other prn administrations of Duoneb were indicated. Oxygen saturations were not indicated as measured at any time on the MAR in June 2011. Oxygen at 2 LPM was indicated as used only on 6/21/11, with a specific time not indicated. During interview completed on 6/22/11 at 3:15 p.m., the Director of Nursing indicated the respiratory therapists provide all respiratory treatments between 5:00 a.m. and 5:30 p.m. seven days a week. She indicated nurses provide the respiratory treatments at other times. During interview on 6/23/11 at 2:10 p.m., the Director of Nursing provided a statement from Resident E's physician, who she indicated was the facility's medical director. The statement was dated 6/22/11 at 5:11 p.m., and indicated the physician had been requested to review the record and indicated, "...Her care had been discussed by myself with			

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	her POA [power of attorney] and with nursing....The care provided followed care discussed with POA. I concur with nursing decision not to call with change in O2 sat due to above factors. Indeed, I would have politely reminded the nurse of the diagnosis/poor prognosis/importance of keeping patient comfortable. No new orders would have been given unless patient showed evidence of being uncomfortable/needing additional medication for comfort needs." During interview on 6/23/11 at 4:15 p.m., LPN #24 indicated the physician's orders for Resident E did not include an order for comfort measures only. 3.1-47(a)(6)			